consciousness, vomiting, convulsions on the left side of the body appeared, and within a few days left-sided hemiplegia, lasting a week and a half was noticed. After the attack the child's mind was somewhat enfeebled and he had nocturnal enuresis. At the age of four years, after a fall from a step, he had a temporary renewal of his former symptoms. A few months later he had another attack with transitory hemiplegia and transitory amaurosis of both eyes without pupillary symptoms. The patient was received into the hospital during this last attack.

The diagnosis of tuberculous meningitis seemed improbable, on account of the transitory nature of the hemiplegia and the bilateral amaurosis, for the latter, Dinkler says, is not a sign of meningitis. The symptoms indicated at least two, and probably three, foci of disease. The motor tract could not have been destroyed. The lenticular nucleus is very vascular, and is a favorite location for encephalitis. It is probable that numerous small hemorrhages occurred in this body, or which is less likely on account of the speedy restitution, in the entire motor cortex of the right side. The amaurosis was believed to be due to lesions in the white matter of both occipital lobes, as its transitory character was not in favor of cortical destruction, or the absence of pupillary symptoms of thalamic lesions.

2. Syphilitic disease of the right frontal lobe with neuritis optica duplex præcipue dextra.

A man, thirty-one years old, complained of severe headache in the frontal and temporal regions, which was more severe on the right side at night Typical mucous plaques, bilateral optic neuritis, involving especially the right side, right-sided mydriasis and disturbance of equilibrium with forced movements toward the left were noticed. The process was undoubtedly syphilitic. The lesion was believed to be a gumma, involving the optic nerves and the right frontal lobe.

3. Syphilitic vascular disease of the left Sylvian artery.

The symptoms in this case, transitory left-sided paralysis of the tongue and arm, formication in arm and leg, etc., could be referred to lesions of the right parietal and temporal regions and basal ganglia. The most interesting features were found in the peculiar sequence of the symptoms, and in the right-sided homonymous hemianopsia, with right-sided optic atrophy and hemianoptic pupillary reaction. SPILLER.

149. ARRET DE DÉVELOPPEMENT DU MEMBRE SUPERIEUR CONSÉCUTIF A LA TRAUMATISM DATANT DE L'ENFANCE, ATROPHIE MUSCULAIRE NUMERIQUE (Numerical Muscular Atrophy in a Case of Arrested Development of the Upper Extremity). Klippel (La Presse Médicale, 62, 1897, p. 49).

Klippel gives the clinical history, and the pathological report in the case of a man who in consequence of an injury to his left elbow at the age of three years, had an arrest of development of the left upper extremity, and who died at the age of 54 from pulmonary tuberculosis. A number of measurements taken during life showed a considerable difference in length and circumference between the right arm and the left. The left elbow joint was completely ankylosed. The very careful and thorough pathological examination showed that there was neither diminution in volume nor change in structure in the histological elements in the affected extremity, but that there was a distinct diminution in their number. The palmaris longus muscle, when measured at the same points on the two sides, gave right, circumference 4½ cm., left 3½ cm. The difference in volume was also evident in other muscles of the forearm. The individual muscle fibres were of the same size on the two sides, but on the left they were fewer in number. The pronator teres and pronator quadratus had disappeared on the left side, their usual position being occupied by an aponeurotic layer. The right median nerve contained nineteen bundles of fibres, the left sixteen, but the individual nerve fibres showed no degeneration. The bones on the left side were altogether smaller than on the right, but their structure was the same. The anterior horn of the spinal cord in the cervical region was smaller on the left side than on the right, and in one section of actual count there were found thirty-five cells in the right, only eighteen in the left anterior horn. In the brain, the right ascending parietal convolution was slightly narrower than the left.

ALLEN.

150. ALIMENTAERE GLYCOSURIE BEI KRANKHEITEN DES CENTRALNERVENSYSTEMS (Alimentary Glycosuria in Diseases of the Central Nervous System). Von Oordt (Münchener Medicin.-Wochenschrift, 1, 1898, p. 2).

The author examined the urine of 178 patients suffering from different diseases of the nervous system, both functional and organic, after having caused to be ingested in each case grape sugar—100 grm. dextrose—under suitable precautions against error. The Trommer, Nylander, Phenylhydrazin and Tenreatatich tests were used and the sugar, when present, was determined quantitatively by the polariscope. He draws the following conclusions. Alimentary glycosuria occurs in a certain percentage of cases.

a. In diseases of the structures within the cranial cavity, and is here caused, partly by encroachment upon the "diabetes centre," partly by central disturbances of nutrition resulting from encroachment upon the cranial space, pain, psychical disturbances and different reflex processes.

b. In a group of functional neuroses, neurasthenia, hysteria and traumatic neuroses.

It does not occur in a number of other neuroses, in true epilepsy; generally not, in diseases of the spinal cord, where there is no involvement of the medulla. Alimentary glycosuria can pass into spontaneous glycosuria.

ALLEN.

151. IST DIE PROGRESSIVE PARALYSE AUS DEN MICROSCOPISCHEN BEFUNDEN AN DER GROSSHIRNRINDE PATHOLOGISCH-ANATOMISCH DIAGNOSTICIRBAR (Can General Paresis be Diagnosed with the Microscope). O. Schmidt (Allgemeine Zeitschrift für Psychiatrie, 54, 1897-98, p. 178).

The author presents an excellent résumé of the various pathological findings which have been described by various authors and which have been regarded as characteristic of the disease. He shows that hardly any of the various lesions are constant. Thus though the vessels are usually affected, they are not always diseased, and moreover similar lesions have been described in other affections. The sclerotic areas are not constant and are subject to much variation. The newer researches on the changes in the ganglion cells would seem to offer the best opportunities for definite conclusions, yet these have not been always corroborated, nor are they universal. The changes in the nerve fibres are inconclusive and the general conclusion would seem to be that a need exists to differentiate anatomical types and correlate if possible the clinical phenomena.

JELLIFFE.